

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1670

CERTIFICATE OF DEATH

10142

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford
 City or town Harford del Grace
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 hr 5 min
 Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
 How long in hospital or institution? 1 hr 5 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Harford
 City or town Bearsden
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Vernette Anthony

3. (b) Social Security Number

4. Sex

F

5. Color or race

Black

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

October 17, 1945

8. AGE:

Years

Months

Days

If less than one day

1 hrs. 5 min.

9. Birthplace

Harford del Grace, Md.
(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

FATHER

12. Name

Eugene Anthony

13. Birthplace

Virginia

MOTHER

14. Maiden name

Virginia Hill

15. Birthplace

Virginia

16. Informant

Address

Virginia Anthony
Bearsden, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

Oct 19 - 1945
(month) (day) (year)

Cemetery or crematory

St. Calvary

Location

Near Aberdeen Md.

18. Funeral director

Address

Benny Ignatius Sons
Aberdeen Md.

19.

Oct-18
(Date rec'd by registrar)

19. 45-

B. L. Lewis M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 17, 1945 at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 17, 1945 to Oct 17, 1945
and that I last saw him alive on Oct 17, 1945

Immediate cause of death

Stillborn

Due to

Due to

Other conditions

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank Updegraff M.D.
Harford del Grace
Date signed Oct 17, 1945

Address

Date signed

RECEIVED
OCT 22 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:

County Hartford

City or town Rural - Shawsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

Whitehall, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Hartford

City or town Rural - Shawsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

James Upton Ayres

3. (b) Social Security Number

NONE

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married-Widower

6. (b) Name of husband or wife

Mary Mullineaux Ayres

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct. 24, 1873

8. AGE:

Years

72

Months

11

Days

19

If less than one day

hrs. min.

9. Birthplace

Hartford Co. Md.

(Town, county, and state)

10. Usual occupation

RETIRED FARMER

11. Industry or business

FATHER

12. Name

THOMAS J. AYRES

13. Birthplace

HARTFORD Co.

MOTHER

14. Maiden name

ALICE NELSON

15. Birthplace

HARTFORD Co.

16. Informant

Mrs. Howard C. Bircham

Address

Tarrettsville, Md.

17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof

OCT. 15 - 1945

Cemetery or crematory

AYRES CHAPEL

Location

WHITE HALL, RD 8 MD

18. Funeral director

Howard S. Marklin

Address

WHITE HALL MD.

Oct. 15
(Date rec'd by registrar)

1945 Thomas R. Brown
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 12, 1945 at Found dead in 4 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Called to see patient after death

and that I last saw him alive on

19

Immediate cause of death

Coronary thrombosis

DURATION

Due to

Coronary Heart disease

3 yrs.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles A. Joffe MD

Address

Tarrettsville, Md.

Date signed

10-13-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 5 1945

BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94

CERTIFICATE OF DEATH

10144

Reg. Dist. No. 150

1. PLACE OF DEATH:

County HarfordCity or town Joppa
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 1/2 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Joppa
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Harry Becker Bell

3.(b) Social Security Number

220-20-7257

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Emily M. Bell

7. Birth date of

deceased (mo., day, yr.)

June 25, 18836.(c) If alive, give age 49 years

8. AGE:

Years

Months

Days

If less than one day

0239

hrs.

min.

9. Birthplace

Maryland, Harford Co
(Town, county, and state)

10. Usual occupation

Retired Govt. Employee

11. Industry or business

Edgewood Arsenal, Md

FATHER

12. Name

Nelson Bell

13. Birthplace

unknown

MOTHER

14. Maiden name

Ellen Bell

15. Birthplace

unknown

16. Informant

Emily M. Bell

Address

Joppa R.D. Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

Oct 7 1945
(month) (day) (year)

Cemetery or crematory

Salena

Location

Upper Falls, Bkly, Co, Md

18. Funeral director

David Davidson

Address

Upper Falls Maryland

19.

(Date rec'd by registrar)

19

45Marie M. Mouladale

Registrar

23. SIGNATURE

Ned O Hodous M.D
M. D. or otherAddress Edgewood Md Date signed 10-4-45

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 19 45 at 3:50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 4 19 36 to Oct 4 19 45and that I last saw him alive on Oct 4 19 45

Immediate cause of death

Coronary Occlusion

DURATION

6 hrs

Due to

Coronary disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Ned O Hodous M.D
M. D. or otherAddress Edgewood Md Date signed 10-4-45

RECEIVED
OCT 10 1945
BUREAU A. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MICHIGAN CORPORATE LIMITED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 72

CERTIFICATE OF DEATH

★ Reg. Dist. No. 185

1. PLACE OF DEATH: *Harford*
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *10 yrs*
 Hospital, institution, or street address where death occurred:
712 So. Washington St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
MD. Harford
 State..... County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *712 So. Washington St.*
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME *Jean Berriker*

3. (b) Social Security Number

4. Sex *Female* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Single*

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) *July 23, 1945-1930* 6. (c) If alive, give age. — years

8. AGE: Years *15* Months *3* Days *6* If less than one day — hrs. — min.

9. Birthplace *Balto. City, Md.*
 (Town, county, and state)

10. Usual occupation *School*

11. Industry or business

12. Name *Jacob W. Berriker*13. Birthplace *Md.*14. Maiden name *Katherine Barnes*15. Birthplace *Md.*16. Informant *Mrs. Sadie R. Barnes*Address *Harrod Grace, Md.*17. *Burial* Date thereof *Nov. 1, 1945*

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Angel Hill*Location *Harrod Grace, Md.*18. Funeral director *R. Madison Mitchell*Address *Harrod Grace, Md.*19. *Nov. 1 -* 19 *45 -* *A. L. Lewis m.*

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 29, 1945* at *8:30 P.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Oct 29, 1945* to *Oct 29, 1945*and that I last saw her alive on *Oct 29, 1945*Immediate cause of death *Cerebral occlusion* DURATION *1 day*Due to *subacute bacterial*Due to *subcutaneous* *5 years*Other conditions *Disease of nail*

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *John Archert MD* M. D. or otherAddress *Harrod Grace, Md.* Date signed *Oct 31, 1945*

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

RECEIVED
NOV 3 1945
BUREAU OF INVESTIGATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (702)

CERTIFICATE OF DEATH



Reg. Dist. No. 182

10146

1. PLACE OF DEATH:

County HartfordCity or town Edgewood Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Accident

Hospital, institution, or street address where death occurred:

Now long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HartfordCity or town Churchville, Md
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

James L. Bishop

3. (b) Social Security Number

4. Sex Male5. Color or race W6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Bertie L Bishop7. Birth date of deceased (mo., day, yr.) May 30 1880

8. (c) If alive, give age _____ years

8. AGE: Years 65 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Wilkes Co., N.C.
(Town, county, and state)10. Usual occupation State Road (Labor)11. Industry or business Repair Roads12. Name James Bishop13. Birthplace N.C.14. Maiden name Nancy15. Birthplace N.C.16. Informant Mrs Bertie L BishopAddress Aberdeen, Md17. Burial Burial Date thereof Oct 26/45
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory TrinityLocation Churchville Md18. Funeral director Dean & InterAddress Bel Air, Md19. 10-25 45 Priscilla Townsend
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23 1945 at 930 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19_____, to _____ 19_____

and that I last saw him _____ alive on _____ 19_____

Immediate cause of death Hemothorax DURATION 5 hrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide A accident Date of 10/23/45Where did injury occur Edgewood Hartford Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) U.S. Route 40Means of injury Hit by truck Injured at work? noSignature Dr. Gerald C. Palmer MDAddress Hartford County Md M. D. or otherDate signed 10/24

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

OCT 26 1945

BUREAU V.R.

RECEIVED FOR RECORDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 852

CERTIFICATE OF DEATH

10147

Reg. Dist. No. 182

1. PLACE OF DEATH:

County Harford
 City or town Bel Air
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year 3 months
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Harford
 City or town Bel Air
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

James Thomas Chewworth

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widower

6. (b) Name of husband or wife Murtha Chewworth

7. Birth date of deceased (mo., day, yr.) Oct 6 1871 6. (c) If alive, give age _____ years

8. AGE: Years 74 Months 0 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Upper Roads Harford Co md
 (Town, county, and state)

10. Usual occupation merchant11. Industry or business Retired12. Name Thomas Austin Chewworth13. Birthplace Balto county md.14. Maiden name Ellen K. Cook15. Birthplace Baltimore md16. Informant Mr Roy ChewworthAddress Fallston md17. Burial Date thereof Nov 3-1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory ProvidenceLocation Fallston md.18. Funeral director Marta G. KuntzAddress Janettsville md.19. 11/11 45 Priscilla L. Woodward

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31 1945 at 2 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 to Oct 31 1945and that I last saw him alive on Oct 31 1945Immediate cause of death Cerebral Hemorrhage DURATION 12 hrs.Due to Previous paralysis

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE P. B. Hopkins M. D. or otherAddress Bel Air md Date signed 10/31/45

RECEIVED STATE DEPARTMENT OF HEALTH

RECEIVED STATE DEPARTMENT OF HEALTH

RECEIVED
NOV 3 1945
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 332

CERTIFICATE OF DEATH

★ Reg. Dist. No. 182

1. PLACE OF DEATH:

County HarfordCity or town Bel-air Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HarfordCity or town Bel-air Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. Mo

(If rural, give LOCATION)

2.(a) If veteran, name war Mo

3. (a) FULL NAME

Lula K. Cullum

3. (b) Social Security Number

Mo4. Sex Female 5. Color or race White 6. (Single, married, widowed, or divorced) Widow6.(b) Name of husband or wife Frank Cullum7. Birth date of deceased (mo., day, yr.) Sept. 22, 18918. AGE: Years 54 Months 1 Days 6 If less than one day hrs. min.9. Birthplace Harford Co., Md
(Town, county, and state)10. Usual occupation Housewife11. Industry or business at home12. Name Shirlean Morris13. Birthplace Harford Co., Md14. Maiden name Lydia Singleton15. Birthplace Harford Co., Md16. Informant Mrs. CullumAddress Abertown, Md, R.R.17. (Burial, cremation, or removal, which?) Burial Date thereof Oct 30 1944
(month) (day) (year)Cemetery or crematorium Churchville CemLocation Harford Co., Md.18. Funeral director H. S. BaileyAddress Burlington, Md.19. 10-29 45 Priscilla Towood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1945, at M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1942 to Oct 1945and that I last saw him alive on Oct 22 1945Immediate cause of death Cerebral Hemorrhage

DURATION

36 hrsDue to Hypertension, essentialDue to 3 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Regle Priscilla Towood M. D. or otherAddress Churchville, Md. Date signed Oct 29

RECEIVED
NOV 1 1945
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 10149 185-

1. PLACE OF DEATH:

County Harford
 City or town Harford
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 hours
 Hospital, institution, or street address where death occurred:
Harford Memorial Hosp.
 How long in hospital or institution? 7 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Harford
 City or town Aberdeen
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Joanne Blackman

3. (b) Social Security Number

4. Sex F 5. Color or race W. 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) October 16, 1945
 8. AGE: Years _____ Months _____ Days _____ If less than one day 7 hrs. _____ min.

9. Birthplace Harford, Md.
 (Town, county, and state)

10. Usual occupation Infant

11. Industry or business _____

12. Name George Bennis

13. Birthplace Virginia

14. Maiden name Bonnie Blackman

15. Birthplace Maryland

16. Informant Bonnie Blackman

Address Aberdeen, Md.

17. Burial Date thereof Oct. 19-1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Good

Location Aberdeen Md.

18. Funeral director Henry Tearing House

Address Aberdeen Md.

19. Oct-18 1945 W. L. Lewis M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 1945, at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19_____, to _____ 19_____,

and that I last saw him _____ alive on _____ 19_____,

Immediate cause of death Neonatal death DURATION _____

(9 months)

Due to asphyxia

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE E. Rye M. D. or other _____

Address Harford, Md. Date signed 10-18-45

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
OCT 22 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THIS CERTIFICATE LIMITED TO

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10150 125

1. PLACE OF DEATH:

County HARFORD
 City or town Rural (Between Havre de Grace, Md. and Aberdeen, Md. 1 mo. 21 da.)
 How long in above place of death? A.W.O.T. Patient from Veterans Administration Facility (Perry Point, Md.)
 Hospital, institution, or street address where death occurred: Same as above
 How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County -
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2908 Springhill Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War II ✓

3. (a) FULL NAME

Leonard Limerick Lumenick

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife -
 6. (c) If alive, give age - years
 7. Birth date of deceased (mo., day, yr.) January 16, 1920
 8. AGE: Years 25 Months 9 Days 3 If less than one day - hrs. - min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)
 10. Usual occupation Pharmacist
 11. Industry or business -
 12. Name Herman Lumenick
 13. Birthplace Unknown
 14. Maiden name Rose (maiden name unknown (Lumenick))
 15. Birthplace Unknown

16. Informant Hospital Records
 Address Veterans Administration, Perry Point, Md.
 17. Burial Date thereof 10-21-45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rosedale
Phily Rd + Hamilton Ave
 Location Jack Lewis Inc
 18. Funeral director Jack Lewis Inc
 Address 2100 Eutaw Pl Balto
 19. 10-19 1945 A. L. Lewis M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 19 45 at 7:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death Fracture skull
 Due to -
 Due to -
 Other conditions Dementia precox
H. ephrenic type
 (Include pregnancy within 8 months of death) over 6 mo.

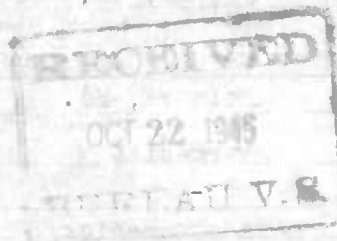
Major findings of operations - Date of op. -

Autopsy results -
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Accident Date of 10-19-45
 Where did injury occur? Aberdeen Harford Md
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where)? B.O. P.P. Harbor
 Means of Injury Hit by train Injured at work? No
 23. SIGNATURE Gerald C Palmer M.D.
County Medical Examiner
 Address 3rd Ave, Md Date signed 10/19/45

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County HarfordCity or town near Fonest Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sarah L. Harkins

3. (b) Social Security Number

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Nov 4 - 1861

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

84727

..... hrs.

..... min.

9. Birthplace

Harford Co Md

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

Philip Quinlan

13. Birthplace

Md.

MOTHER

14. Maiden name

Elizabeth Taylor

15. Birthplace

England

16. Informant

Mrs. A. G. Harkins

Address

Stallbrook Apts Balb

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

Nov. 2 - 45

(month) (day) (year)

Cemetery or crematory

Centra Ch. Cem

Location

Fonest Hill Md.

18. Funeral director

Clarence E. Arthur

Address

Fork Md.

19.

(Date rec'd by registrar)

11-1-45

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1945 at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 30, 1945 to Oct. 31, 1945and that I last saw him alive on October 30, 1945

Immediate cause of death

Coronary heart
atherosclerosis

Due to

heart disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Clifford F. Hudson, M.D.

M. D. or other

Address

Fork Md.

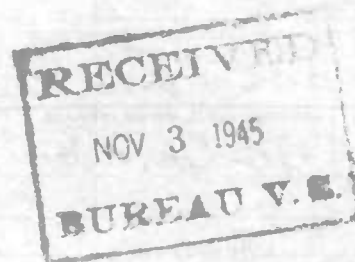
Date signed

11/1/45

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

STATE OF NEW YORK



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CIVIL CORPORA LIMITED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (370)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford CountyCity or town Harre de Grace Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 16 days

Hospital, institution, or street address where death occurred:

Harford Memorial HospitalHow long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Aberdeen - P.O.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2.(a) if veteran, name war none

3. (a) FULL NAME

Lemuel H. Harvey

3. (b) Social Security Number

none4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Susan Elizabeth Mallick7. Birth date of deceased (mo., day, yr.) Aug. 17 - 18658. AGE: Years 80 Months 2 Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name John Harvey13. Birthplace Maryland14. Maiden name Margaret Mitchell15. Birthplace Maryland16. Informant Hospital RecordAddress Harre de Grace, Md.17. Burial Burial Date thereof Oct. 29 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Bakers CemeteryLocation Near Aberdeen18. Funeral director Henry Tarrington & SonsAddress Aberdeen Md.19. Oct-29 45- A. L. Lewis Jr.
(Date rec'd by registrar) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 19 45, at 8:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 45 to Oct 19 45 and that I last saw him alive on Oct 26 19 45Immediate cause of death breast DURATION 30 daysDue to the HepatitisDue to arteriosclerosis C.V.Other conditions Diabetes

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE W. R. R. W. R. R. M. D. or other _____Address Chesapeake Date signed Oct 25

STATE OF MICHIGAN DEPARTMENT OF HEALTH

STATE OF MICHIGAN DEPARTMENT OF HEALTH

RECEIVED

NOV 3 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

10153

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County HarfordCity or town Bel-air
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HarfordCity or town Bel-air
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Sarah Agness Heck

3. (b) Social Security Number

No

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

John Earl Heck

7. Birth date of

deceased (mo., day, yr.)

Alma

8. (c) If alive, give age _____ years

Oct. 15 1877

8. AGE:

Years

Months

Days

If less than one day

6812

_____ hrs.

_____ min.

9. Birthplace

Harford Co. Md
(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

At Home

12. Name

Mrs. M. J. Hilditch

13. Birthplace

Harford Co. Md.

14. Maiden name

Margaret Hecker

15. Birthplace

Harford Co. Md.

16. Informant

John E. Heck

Address

Harriet Hill Md. R.D.

17.

(Burial, cremation, or other)

Date thereof

Oct 31 1946
(month) (day) (year)

Cemetery or crematory

H. J. Constanter Cem.

Location

Harford Co. Md.

18. Funeral director

H. J. Bailey

Address

Barlingtor Md

19.

10-29

19

45 Pucella Toward

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1945 at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 1937 to Oct 27 1945and that I last saw h. alive on October 27 1945

Immediate cause of death

Coronary occlusion

DURATION

12 hours

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

Gerald C Palmer M.D.

Address _____

Date signed

Bel Air, Md. 10/27/45

RECEIVED

RECEIVED

RECEIVED NOV 1 1945
BUREAU V.E.

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct use is especially important. Physicians: please write the causes of death clearly and legibly.

CITIZEN CORPORATION LIMITED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15-6

CERTIFICATE OF DEATH

★ Reg. Dist. No. 185

1. PLACE OF DEATH:

County HarfordCity or town Harveys Beach
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 mo. 27 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Gloria L. Hipkins

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

B. (b) Name of husband or wife

B. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

12/17/44

8. AGE:

Years

Months

Days

If less than one day

927

..... hrs.

..... min.

9. Birthplace

Harveys Beach
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

12. Name

Walter H. Hipkins

13. Birthplace

Aberdeen

MOTHER

14. Maiden name

Olive Smith

15. Birthplace

Aberdeen

16. Informant

Walter H. Hipkins

Address

711 Lewis St. Harveys Beach

17.

(Burial, cremation, or removal. Which?)

Date thereof

10/16/45
(Month) (day) (year)

Cemetery or crematory

Angel Hill

Location

Harveys Beach

18. Funeral director

Remington & Son

Address

Harveys Beach

19.

(Date rec'd by registrar)

19 45G. L. Lewis M. D.
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Harveys Beach
(If outside city or town limits, write RURAL and give nearest town)

Street No.

711 Lewis

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 1519 45at 11:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 1519 45to Oct 1519 45

and that I last saw him alive on

October 1519 45

Immediate cause of death

Streptococcus Infection
of throat

DURATION

2 days

Due to

Due to

Other conditions

Refractive Hemorrhage1 day

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank Wolcott M.D.

M. D. or other

Address

Harveys Beach

Date signed

Oct 15 1945

RECEIVED BY THE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF CALIFORNIA

DATE OF DEATH

DEPARTMENT OF HEALTH

RECEIVED

OCT 17 1945

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10155

Reg. Dist. No. 182

1. PLACE OF DEATH:

County Harford CountyCity or town Benson Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HarfordCity or town Benson Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charles E. Homberger

3. (b) Social Security Number

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Laura E. Homberger

7. Birth date of deceased (mo., day, yr.)

July 19 - 1864

8. (c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

8138

hrs.

min.

9. Birthplace

(Town, county, and state)

Funeral Director

10. Usual occupation

11. Industry or business

FATHER

12. Name

Stewart Homberger

13. Birthplace

Md.

MOTHER

14. Maiden name

Ellen Farnor

15. Birthplace

Md.

16. Informant

Address

Chas. E. GrossBenson Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Oct. 30 - 45

Cemetery or crematory

Friendship Cem

Location

F. A. Stanton Md.

16. Funeral director

Address

Clarence E. ArthurFork Md.

19.

(Date rec'd by registrar)

10 - 291945Priscilla Rowood

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1945 at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

injury 1945 to Oct. 27 1945and that I last saw him alive on Oct. 26 1945

Immediate cause of death

Cerebral Thrombosis

DURATION

3 daysDue to Hypertensive (cardio)vascular diseaseDue to GeneralarteriosclerosisOther conditions See History aux

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

Clarence E. ArthurFork Md.10/28/45

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

RECEIVED
OCT 30 1945
BUREAU OF VITALS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OTHER CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131a)

CERTIFICATE OF DEATH

Reg. Diat. No. 125

1. PLACE OF DEATH

County HarfordCity or town Harre del Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)Street No. Rt # 2
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

David Hutchinson

3.(b) Social Security Number

4. Sex

M

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Unknown

7. Birth date of

deceased (mo., day, yr.)

May 6, 1857

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

88517

hrs.

min.

9. Birthplace

Harford Co. Maryland
(Town, county, and state)

10. Usual occupation

retired farmer

11. Industry or business

FATHER

12. Name

Unknown

MOTHER

13. Birthplace

IA

14. Maiden name

II

15. Birthplace

II

16. Informant

Mrs. Granville Byle - (Friend)

Address

Aberdeen, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Oct. 26-1945
(month) (day) (year)

Cemetery or crematory

Bakus

Location

Aberdeen Md.

18. Funeral director

Benny Tarrington

Address

Aberdeen Md.

19.

(Date rec'd by registrar)

10-25-45A. L. Lewis MD

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1945 at 7:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1945 to Oct 27 1945
and that I last saw him alive on Oct 1945

Immediate cause of death

Arteriosclerosis
Hypertension
Chronic Myocarditis
Chronic Nephritis

Due to

Due to

Other conditions

Cachexia
Toxemia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Charles J. Foley MD
Harre del Grace

M. D. or other

Date signed 10/25/45

RECEIVED
OCT 27 1945
BUREAU V.S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

119

119

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

10157

Reg. Dist. No. 182

1. PLACE OF DEATH:

County Harford

City or town Belt Air
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Belt Air
(If outside city or town limits, write RURAL and give nearest town)

Street No. 127 Alice Green St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Hannah M. Kell

3. (b) Social Security Number

4. Sex Female

5. Color or race Negro

6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mathew A Kell

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5, 1897

8. AGE: Years 48 Months 7 Days 27 If less than one day

9. Birthplace Clarks Chapel Md
(town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John J. Williams

13. Birthplace Maryland

14. Maiden name Rachel Collins

15. Birthplace Maryland

16. Informant Mr. Mathew Kell

Address 127 Alice Green St Belt Air

17. Burial Date thereof Oct 4 45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Clarks Chapel

Location Harford County, Md

18. Funeral director Elmer E. Bullock

Address 55 Lewis A. Howard Ave

19. 10-8 45 Priscilla Toward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1945, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10-1 1945, to 10-1 1945

and that I last saw him alive on 10-1 1945

Immediate cause of death Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Gerald C Palmer MD

Address Belt Air Md

Date signed 10/3/45

RECEIVED
OCT 5 1945
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10158

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County HarfordCity or town Windsor Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

Harford Memorial HospitalHow long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Perryman

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Walter Kenly

3. (b) Social Security Number

4. Sex

M

5. Color or race

Negro

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) September 9, 1945

6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

It less than one day

27

hrs.

min.

9. Birthplace

Perryman, Harford Co., Md.

(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

FATHER

12. Name Walter Edward Kenly

MOTHER

13. Birthplace Maryland

14. Maiden name

Flossie Kenly

15. Birthplace

Maryland

16. Informant

Flossie Kenly - Mother

Address

Perryman, Md.

17.

BuriedDate thereof Oct. 9 - 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Union M. C.

Location

Near Aberdeen Md.

18. Funeral director

Henry Tanning Sons

Address

1 Aberdeen Md.

19.

Oct - 819 45U. L. Lewis M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10, 1945 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 1 19 45 to Oct 6 19 45and that I last saw him alive on Oct - 5 19 45

Immediate cause of death

Malaria

DURATION

1 week

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James W. Welch M.D.

M. D. or other

Address Lawrenceville, Md. Date signed Oct 6, 1945

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF MASSACHUSETTS

DEPARTMENT OF HEALTH

RECEIVED
OCT 9 1945
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10159

182

1. PLACE OF DEATH:

County HartfordCity or town Bel Air (Rural)
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 43 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County HartfordCity or town Bel Air, Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

ms Joanna R Milway

3. (b) Social Security Number

4. Sex F5. Color or race White6.(a) Single, married, widowed or divorced Widow6.(b) Name of husband or wife Kinsey D Milway7. Birth date of deceased (mo., day, yr.) April 27 / 1972

6.(c) If alive, give age _____ years

8. AGE: Years 73 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace MD
(Town, county, and state)10. Usual occupation House Duties

11. Industry or business

12. Name Elijah B Holland13. Birthplace MD14. Maiden name Joanna Rutledge15. Birthplace MD16. Informant Miss Helen MilwayAddress Bel Air, MD17. Burial Date thereof Oct 14 / 45
(Burial, cremation, or removal Which?) (month) (day) (year)Cemetery or crematory St Mary'sLocation Emmorton, MD18. Funeral director Deary & LaidAddress Bel Air MD19. 10-13 45 Piscilla Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12 19 45 at 4:25 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 11 19 45 to Oct 12 19 45and that I last saw him alive on Oct 12 19 45Immediate cause of death coronary occlusion DURATION 30 minDue to arterial sclerotic heart disease several years

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Thos O Hodous M.D. M. D. or otherAddress Edgewood MD Date signed 10/12-45

RECEIVED
OCT 16 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County HartfordCity or town Hamden Place
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 63 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HartfordCity or town Hamden Place
(If outside city or town limits, write RURAL and give nearest town)Street No. 220 N. Washington
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Hannah B. Newmeyer

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widow

6.(b) Name of husband or wife

Solomon Newmeyer (dec.)

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

May 17 - 1861

8. AGE:

Years

Months

Days

If less than one day

8459

hrs.

min.

8. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual occupation

Home wife

11. Industry or business

FATHER

12. Name

Abraham Blumenthal

13. Birthplace

Germany

14. Maiden name

Caroline Neustamm

15. Birthplace

Germany

16. Informant

Emanuel Newmeyer

Address

Hamden Place, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

10/28/45
(month) (day) (year)

Cemetery or crematory

Bethr. Hebrew

Location

Baltimore, Md.

18. Funeral director

Funerary Home

Address

Hamden Place, Md.

19.

Oct. 28
(Date rec'd by registrar)

19

45A. L. Lewis M. D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 26

19

45

at

1 P

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June

19

27

to

Oct 26

19

45and that I last saw her alive onOct 26

19

45

Immediate cause of death

Diabetes Mellitus 20 yrs.
Arteriosclerosis
Cerebral Hemorrhage
Coronary Thrombosis

DURATION

Due to

Due to

Other conditions

Toxemia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Clint J. Foley M.D.

M. D. or other

Address

Hamden Place, Md.

Date signed

10/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
NOV 3 1945
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 169

CERTIFICATE OF DEATH

Reg. Dist. No. 10161 181

1. PLACE OF DEATH:

County HarfordCity or town Chesden md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 mo

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Chesden
(If outside city or town limits, write RURAL and give nearest town)Street No. 437 W. Del Air Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Nellie L. Peterson

3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband Art. Arthur E. Peterson6. (c) If alive, give age 52 years7. Birth date of deceased (mo., day, yr.) Oct. 24 18938. AGE: Years 51 Months 11 Days If less than one day hrs. min.9. Birthplace Round Hill Va
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Samuel E. Bindman13. Birthplace Round Hill Va.14. Maiden name Mollie L. Howell15. Birthplace Round Hill, Va.18. Informant Arthur E. PetersonAddress 437 Del Air Ave.17. Burial Date thereof Oct. 14 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baker'sLocation Chesden md18. Funeral director Henry J. J. JonesAddress Chesden md19. Oct. 13 19 45 Nellie H. Poley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10 19 45 at 209 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 19 19 and that I last saw h alive on 19 Immediate cause of death Fracture skull

DURATION

Due to Due to Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 10/10/45Where did injury occur? Aberdeen Harford md (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Pinna R.R. tracksMeans of injury H. T. by train Injured at work? no23. SIGNATURE Devid E. Palmer MDAddress 10113/48

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

CERTIFICATE OF DEATH

STATE OF NEW YORK

NOTICE OF DEATH

RECEIVED
18 1945
AU V.S.

RECEIVED
OCT 18 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-5

CERTIFICATE OF DEATH

Reg. Dist. No. 101625

1. PLACE OF DEATH

County HarfordCity or town Harford
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 yr. 6 mo.

Hospital, institution, or street address where death occurred:

St. Francis Villa, HarfordHow long in hospital or institution? 1 yr. 6 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Harford
(If outside city or town limits, write RURAL and give nearest town)Street No. Commerce & Market
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Dr. M. Purissima (Bertrude Moers)

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan. 14 - 1882 6.(c) If alive, give age - years8. AGE: Years 63 Months 9 Days 7 If less than one day - hrs. - min.9. Birthplace Germany
(Town, county, and state)10. Usual occupation Housekeeper

11. Industry or business

12. Name Henny Moers13. Birthplace Germany14. Maiden name Johanna Belzer15. Birthplace Germany16. Informant Hosp. RecordsAddress Commerce & Market, Harford17. Burial Date thereof 10/23/45
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory St. Peter'sLocation Near Philadelphia Pa.18. Funeral director Permyington & SonAddress Harford19. 10-22 19 45 A. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1945 at 9:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945 to Oct 21 1945 and that I last saw him alive on Oct 21 1945

Immediate cause of death

DURATION

PulmonaryDue to Tuberculosis

Due to

Other conditions

Cachexia
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address Harford Date signed 10/23/45

RECEIVED

OCT 24 1945

BUREAU V.M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 10163 182

1. PLACE OF DEATH:
County.....*Harford County*
City or town.....*Shelton*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....*Life*
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State.....*md* County.....*Harford*
City or town.....*Shelton*
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....*Spanish American*

3. (a) FULL NAME
William Francis RILEY

3. (b) Social Security Number

4. Sex.....*M* 5. Color or race.....*W* 6. (a) Single, married, widowed, or divorced.....*married*
6. (b) Name of husband or wife.....*Rhoda Chenorth*
7. Birth date of deceased (mo., day, yr.).....*June 30, 1896*
8. AGE: Years.....*69* Months..... Days..... If less than one day..... hrs. min.

9. Birthplace.....*Maryland*
(Town, county, and state)
10. Usual occupation.....*Retail mail carrier*
11. Industry or business.....

FATHER 12. Name.....*James Riley*
13. Birthplace.....*Ireland*
MOTHER 14. Maiden name.....*Bridget Moran*
15. Birthplace.....*Ireland*

16. Informant.....*Mrs. W. S. Riley*
Address.....*Shelton md*
17. Burial.....*Burial* Date thereof.....*10/15/45*
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....*St John's*
Location.....*Long Green md*
18. Funeral director.....*Hamberger & Co*
Address.....*Benson md*

19. *10-12* 19 *45* *Priscilla Fournood*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*October 12* 19 *45* at *5A* M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *June 1* 19 *40* to *Oct 12* 19 *45*
and that I last saw him alive on *Oct 16* 19 *45*

Immediate cause of death.....*Hypertensive C V disease* DURATION.....*3 years*

Due to.....
Due to.....
Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?

23. SIGNATURE.....*Gerald C Palmer md* M. D. or other
Address.....*Bel Air md* Date signed *10-12-45*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13191

THE UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C. 20530

RECEIVED

OCT 16 1945

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

OCT 16 1945

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 733

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County..... HarfordCity or town..... Bell Air, Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... HarfordCity or town..... Bell Air, Md
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Elizabeth K Scarff

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W

8. (b) Name of husband or wife

Philip G Scarff

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

April 18 - 1959

8. AGE:

86

Months

Days

If less than one day

hrs. min.

9. Birthplace

Fallston

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

Robt. Watters

13. Birthplace

Md

MOTHER

14. Maiden name

Elizabeth Hahn

15. Birthplace

Baltimore Md

16. Informant

Mrs Stanley Preston

Address

Bell Air, Md17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Oct 30 1945
(month) (day) (year)

Cemetery or crematory

Friendship

Location

Fallston Md

18. Funeral director

Dean J Foster

Address

Bell Air, Md19. 10-29

(Date rec'd by registrar)

19 46 Priscilla Toward

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Oct 28 1945 at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....1925 to Oct 1945and that I last saw him alive on Aug 1945Immediate cause of death myocarditis & acute dilation

DURATION

SuddenDue to Age - Chronic myocarditis

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or otherAddress..... Bell Air, Md Date signed 10/29/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 10165 183

1. PLACE OF DEATH:

County HarfordCity or town Harpsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa County HarfordCity or town White Hall PA
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Grace H. L. L.

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) April 21, 18798. AGE: Years 66 Months 6 Days 6 It less than one day _____ hrs. _____ min.9. Birthplace Harford Co Md
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Farming12. Name Harry V. Lutz13. Birthplace White PA14. Maiden name Anna Oving15. Birthplace White PA16. Informant Mrs. Blanche PlummerAddress 1700 Grove Rd17. Burial Date thereof Oct 30, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory HarpsvilleLocation Harpsville Md18. Funeral director W. Howard WebbAddress 1700 Grove Rd19. Oct 30 1945 Thomas P. Brown
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1945, at 7:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 15 1945, to Oct 25 1945and that I last saw him alive on Oct 25 1945Immediate cause of death Thromb Myocarditis

DURATION

5 yrs?

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Edward H. Hyman

M. D. or other

Address 1700 Grove Rd Date signed Oct 27, 1945

RECEIVED

NOV 5 1945

BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (241)

CERTIFICATE OF DEATH

Reg. Dist. No. 101685

1. PLACE OF DEATH:

County... HarfordCity or town... Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?... 3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... HarfordCity or town... Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)Street No. 555 Fountain St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Herbert Aubrey Southall

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married8. (b) Name of husband or wife Reba Weaver Southall

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) May 29 - 19068. AGE: Years 39 Months 4 Days 14 If less than one day... hrs. ... min.9. Birthplace Buckingham Co., Va.
(Town, county, and estate)10. Usual occupation Foreman11. Industry or business Coca Cola12. Name Henry Ayers Southall13. Birthplace Va.14. Maiden name Sarah V. Jones15. Birthplace Va.16. Informant Mr. Reba W. SouthallAddress 555 Fountain St. Havre de Grace17. Burial Date thereof Oct. 16 - 45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Farmville CemeteryLocation Farmville Va.18. Funeral director Pennington & SonAddress Havre de Grace Md.19. Oct-15 19 45 G. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 19 45 at... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19... and that I last saw him alive on Oct 14 - 45 19...Immediate cause of death Coronary occlusionDue to hypertrophic cardiomyopathyDue to arteriosclerosisOther conditions arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. L. Lewis M.D. M. D. or otherAddress Havre de Grace Md. Date signed Oct-15-45

CERTIFICATE OF DEATH

RECEIVED
OCT 16 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 575

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH: County... <i>Narford</i> City or town... <i>Narford Grace</i> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: <i>Narford Memorial Hospital</i> How long in hospital or institution? <i>16 days</i>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants, give residence of mother) State... <i>MD.</i> County... <i>Narford</i> City or town... <i>Narford Grace</i> (If outside city or town limits, write RURAL and give nearest town) Street No. <i>675 Bourbon</i> (If rural, give LOCATION) 2.(a) If veteran, name war...			
3. (a) FULL NAME <i>William Ross Stephens</i>				3. (b) Social Security Number			
4. Sex <i>Male</i>		5. Color or race <i>White</i>		6. (a) Single, married, widowed, or divorced <i>Married</i>			
6. (b) Name of husband or wife <i>Eva Jane Stephens</i>				6. (c) If alive, give age <i>80</i> years			
7. Birth date of deceased (mo., day, yr.) <i>June 4, 1866</i>				8. AGE: Years <i>79</i> Months <i>3</i> Days <i>28</i> If less than one day hrs. min.			
9. Birthplace <i>Penn.</i> (Town, county, and state)				10. Usual occupation <i>Carpenter</i>			
11. Industry or business <i>John Stephens</i>				12. Name <i>John Stephens</i>			
13. Birthplace <i>Penn.</i>				14. Maiden name <i>Elizabeth Chandler</i>			
15. Birthplace <i>MD.</i>				16. Informant <i>Mrs. Eva Jane Stephens</i> Address <i>675 Bourbon St. City.</i>			
17. (Burial, cremation, or removal, Which?) <i>Burial</i> Date thereof <i>Oct 4, 1945</i> (month) (day) (year) Cemetery or crematory <i>Salem, York Co., Penn.</i> Location <i>York Co., Penn.</i>				18. Funeral director <i>T. P. Madison Mitchell</i> Address <i>Narford Grace MD.</i>			
19. (Date rec'd by registrar) <i>Oct-2</i> 19 <i>45</i>				20. Signature <i>A. P. Lewis M.D.</i> Address <i>Narford Grace MD.</i> Date signed <i>Oct-2-45</i>			

MEDICAL CERTIFICATION

20. DATE OF DEATH... *Oct 2, 1945* at *1:40* M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Sept-8* 19 *45* to *Oct 2* 19 *45*
 and that I last saw him alive on *Oct 1* 19 *45*

 Immediate cause of death... *ursemia*
 Due to *Edwards (Kretz) (Possibly Carcinoma)*
 Due to *Chronic Nephritis*
 Other conditions...
 (Include pregnancy within 8 months of death)

 Major findings of operations...
 Date of op...

 Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)

 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

RECEIVED
OCT 4 1965
EXHIBIT A.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

10168

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County HarfordCity or town Harford
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hosp.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Magnolia
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2(a) if veteran, name war

3. (a) FULL NAME

Armanda Jane Stevenson

3. (b) Social Security Number

4. Sex

F

5. Color or race

Black

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

John Stevenson

7. Birth date of deceased (mo., day, yr.)

April 5, 1880

6. (c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

65618hrs.min.

9. Birthplace

Perryman, Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Henry Williams

13. Birthplace

Maryland

MOTHER

14. Maiden name

Olivia Norton

15. Birthplace

Maryland

16. Informant

Eva Toliver - Daughter

Address

Magnolia, Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 10-28-45

(month) (day) (year)

Cemetery or crematory

Magnolia Md

Location

Harford Co. Md

18. Funeral director

Matthew A. Hemley

Address

578 W. Bridge St19. Dec

(Date rec'd by registrar)

45Dec281945

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23, 1945 at 10:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 23, 1945 to Oct. 23, 1945and that I last saw him/her alive on October 23, 1945

Immediate cause of death

Cerebral hemorrhageintraventriculargeneralizedarteriosclerosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles J. Foley MD

M. D. or other

Address Harford Co. MdDate signed 10/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 582+

CERTIFICATE OF DEATH



Reg. Dist. No. 10169 183

1. PLACE OF DEATH:

County Harford
 City or town Rocke
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Harford
 City or town Rocke
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Daisy Stewart

3. (b) Social Security Number

4. Sex Female 5. Color or race col 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Howard Stewart
 6.(c) If alive, give age 64 years
 7. Birth date of deceased (mo., day, yr.) apr 19 1877
 8. AGE: Years 58 Months 5 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Home
 12. Name Jacob Bradford
 13. Birthplace Harford co md
 14. Maiden name Mary J. Bond
 15. Birthplace German town Penna

16. Informant Jillie Stewart
 Address Rocke md
 17. Burial Burial Date thereof Oct 21 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory clarks chapel
 Location Bel Air Harford co md
 18. Funeral director Martin Skantz
 Address Lanctsville md
 19. Oct 21 1945 Thomas C Brown
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1945, at 3:50 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1943 to October 18 1945
 and that I last saw him alive on October 17 1945
 Immediate cause of death Metastatic carcinoma
 Due to Primary abdominal carcinoma
 Due to Anatomical primary site unknown
 Other conditions Cervix
 (Include pregnancy within 3 months of death)

DURATION

?

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Enoch G. Hunt MD M. D. or other _____
 Address Carroll, MD Date signed 10/18/45

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

OFFICE OF THE REGISTRAR

RECEIVED
NOV 5 1945
BUREAU OF VITALS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for reasons why the certifi is not completely filled out is shown on G99 11-14-45

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 200-01

CERTIFICATE OF DEATH

10170
181
★ Reg. Dist. No.

1. PLACE OF DEATH:County..... Aberdeen HarfordCity or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAMEUnknown Baby**3.(b) Social Security Number**

4. Sex

Female

5. Color or race

Col

6.(a) Single, married, widowed, or divorced

MEDICAL CERTIFICATION20. DATE OF DEATH..... Oct 1 19 45 at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 1B..... to..... 19.....
and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

unknown**DURATION**

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Not known Date of..... ?Where did injury occur?..... Aberdeen Harford Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Not known Injured at work?.....23. SIGNATURE..... Derald C Palmer M.D.**DEPUTY MEDICAL EXAMINER****HARFORD COUNTY M. D. or other**Address..... Bel Air Md Date signed 10/15/45

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... the child was found with a 10lb

8. AGE: Years..... Months..... Days..... If less than one day.....

ash weight on neck, abandoned in hrs. filed min.Didn't know age Decomposed badly but I (Dr.

B. Birthplace..... (Town, county, and state)

Palmer) estimate it was a new born Sex unknown

10. Usual occupation.....

11. Industry or business

FATHER

12. Name.....

MOTHER

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial Date thereof..... Oct 17-1945
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory..... Union 74-ELocation..... Near Aberdeen18. Funeral director..... Henry Tanning HouseAddress..... Aberdeen Md19. Oct 17 19 45 Nellie A Piley
(Date rec'd by registrar) Registrar

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
NOV 3 1945
BUREAU Y.C.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH

County HarfordVillage or City Barlington Rural

No.

Registration Dist. No. 10171

St.

Ward

Length of residence in city or town where death occurred

yrs.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

mos.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

2. FULL NAME

Carroll Webster

(a) Residence: No.

St.

Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Colored5. SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)Married5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE ofAnnie Webster

6. DATE OF BIRTH (month, day, and year)

Oct. 1, 1888

7. AGE

Years

Months

Days

If LESS than

1 day, _____ hrs.
or _____ min.5726

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BDDKKEEPER, etc.Farmer9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.Crop Farmer10. Date deceased last worked at
this occupation (month and
year)Sept. 1, 194511. Total time (years)
spent in this
occupation25 yrs12. BIRTHPLACE (city or town)
(State or country)Harford Co., Md

FATHER

13. NAME

Moses C. Webster14. BIRTHPLACE (city or town)
(State or country)Harford Co., Md.

MOTHER

15. MAIDEN NAME

Georgia C. Valentine16. BIRTHPLACE (city or town)
(State or country)Harford Co.,
Md.

17. INFORMANT

(Address)

Mrs. Annie C. Webster
Barlington, Md.

18. BURIAL, CREMATION, OR REMOVAL

Place

Date

Harford Cem. Oct. 31, 1945

19. UNDERTAKER

(Address)

H. S. Bailey
Barlington, Md.

20. FILED

Oct. 30, 1945, M. H. Kirk

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

October 27, 1945
(Month) (Day) (Year)

22. I HEREBY CERTIFY That I attended deceased from

Sept 13, 1945, to Oct 27, 1945

I last saw him alive on _____, 19____; death is said

to have occurred on the date stated above, at _____ m.

The PRINCIPAL CAUSE OF DEATH and related causes of Importance
were as follows:Typhoid fever
Acute myocarditis

Date of onset

Sept 13-4510-27-45

Other Contributory Causes of importance:

Cholelithiasis10-1-45

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy? Yes

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HDME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

Boyle L. Brown
Harford Co., Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write *housewife* in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write *none*.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE CORPORATE LIMITED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

101725
Reg. Dist. No.

1. PLACE OF DEATH:
County Harford
City or town Harvile Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 yrs
Hospital, institution, or street address where death occurred:
331 N. Union Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Harvile Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 331 N. Union Ave
(If rural, give LOCATION)
2.(a) If veteran, name war World War # I

3. (a) FULL NAME

Conrad Daniel Zimmermann

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Pearl M. Zimmermann
7. Birth date of deceased (mo., day, yr.) July 9, 1890 - 1890 6.(c) If alive, give age 52 years
8. AGE: Years 55 Months 3 Days 7 If less than one day — hrs. — min.

9. Birthplace Germany
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business
12. Name Conrad D. Zimmermann
13. Birthplace Germany
14. Maiden name Catherine Essner
15. Birthplace Germany

16. Informant Mrs. Pearl M. Zimmermann
Address 331 N. Union Ave. City.
17. Burial Date thereof Oct 18, 1945
(Burial, cremation, or removal, which?) (month) (day) (year)
Cemetery or crematory Western Cemetery
Baltimore Md.
Location R. Madison Mitchell
18. Funeral director Harvile Grace, Md.
Address

19. Oct. 17 1945 And. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 1945 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19— to — 19—
and that I last saw him — alive on — 19—

Immediate cause of death Coronary occlusion
DURATION

Due to —
Due to —
Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of Injury — Injured at work? —

23. SIGNATURE Deputy Medical Examiner
Harford County M. D. or other —
Address Baltimore, Md. Date signed 10-16-45

RECEIVED
OCT 18 1945
BUREAU V.E.